CITY OF STAMFORD
HEALTH CARE PROGRAM ENROLLMENT/CHANGE FORM

Benefits Department (203) 977-4070 or 977-4038

PERSONAL INFORMATION

LAST NAME	FIRST NAME	M.I.	SEX	MARITAL STATUS: ☐ Married ☐ Single
			☐ M ☐ F	EMPLOYMENT STATUS: ☐ Active ☐ Retiree ☐ COBRA

STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE	ENROLLMENT TYPE:
				(H)_____ (C)_____	☐ New Hire ☐ Add Dependents ☐ Other Changes

Social Security Number	CHANGE TYPE: ☐ Change Address ☐ Change Name	QUALIFYING EVENT	UNION AFFILIATION
___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ **Delete** Dependents ☐ **Add** Dependents	_____	
EFFECTIVE DATE / /	☐ **Drop coverage**	QUALIFYING EVENT DATE: / /	

EMPLOYEE AND FAMILY INFORMATION - Please list yourself and all eligible dependents to be enrolled. Eligible dependents include your spouse and/or children. Children can be covered until their 26th birthday provided they do not have access to medical coverage through their employment or their spouse's employment.

	LAST NAME, FIRST NAME, M.I.	DATE OF BIRTH	SOCIAL SECURITY #	SEX	DEPENDENT STATUS	PRIMARY CARE PHYSICIAN #	PHYSICIAN'S FULL NAME
☐ SELF					N/A		
☐ SPOUSE					N/A		
☐ SON ☐ DAUGHTER					Does this dependent have access to health insurance other? ☐ Y ☐ N		
☐ SON ☐ DAUGHTER					Does this dependent have access to health insurance? ☐ Y ☐ N		
☐ SON ☐ DAUGHTER					Does this dependent have access to health insurance? ☐ Y ☐ N		
☐ SON ☐ DAUGHTER					Does this dependent have access to health insurance? ☐ Y ☐ N		

I elect to enroll/disenroll in the coverage listed above and have chosen to enroll/disenroll the aforementioned dependents. I understand that this election is binding and cannot be changed until the next Annual Enrollment Period unless I experience a change in Family Status as outlined under Section 125 of the Internal Revenue Code. I hereby authorize my employer, The City of Stamford, to deduct the negotiated cost of this coverage from my paycheck. I agree and understand that my eligible dependents include my spouse and my biological, adopted and/or step children until their 26th birthday provided they do not have access to medical coverage through their own or their spouse's employment.

Signature:_____ Date:_____

Office Use Only Employee ID#_____

____Ceridian ____Cigna ____Davis ____Delta ____Medco ____Excel H.R. Approval:_____